



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, www.HealthReformPlanSBC.com or by calling 1-877-292-2480. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary/> or call 1-877-292-2480 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u>?	<u>Network</u> : Individual \$400 / Family \$1,200. Out-of-Network: Individual \$1,000 / Family \$3,000.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u>?	Yes. Emergency care & inpatient hospital services; plus in- <u>network</u> <u>preventive care</u> are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	<u>Network</u> : Individual \$1,400 / Family \$4,200. Out-of-Network: Individual \$3,000 / Family \$9,000.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u>?	<u>Premiums</u> , <u>balance-billing</u> charges & health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u>?	Yes. See www.aetna.com/docfind or call 1-877-292-2480 for a list of Aexcel designated <u>providers</u> .	You pay the least if you use a <u>provider</u> in Aexcel Designated. You pay more if you use a <u>provider</u> in <u>Network</u> or Aexcel Non-Designated. You will pay the most if you use an <u>out-of-network provider</u> and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u>?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Aexcel Designated Provider (You will pay the least)	Network Provider (You will pay more)	Aexcel Non-Designated Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	20% <u>coinsurance</u>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	<u>Specialist</u> visit	20% <u>coinsurance</u>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	<u>Preventive care</u> / <u>screening</u> /immunization	No charge	No charge	No charge	Not covered, except 40% <u>coinsurance</u> for mammograms	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	Not applicable	20% <u>coinsurance</u>	Not applicable	40% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	Not applicable	20% <u>coinsurance</u>	Not applicable	40% <u>coinsurance</u>	None
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at	Generic drugs	Not applicable	30% <u>coinsurance</u> with minimum & maximum/prescription: \$10 minimum & \$100 maximum (retail), \$20 minimum & \$200 maximum (mail order)	Not applicable	Not covered	Covers 31 day supply (retail), 32-90 day supply (mail order). Includes contraceptive drugs & devices obtainable from a pharmacy. No charge for preferred generic FDA-approved women's contraceptives <u>in-network</u> .

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Aexcel Designated Provider (You will pay the least)	Network Provider (You will pay more)	Aexcel Non-Designated Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
www.aetnapharmacy.com/premierplus Premier Plus Formulary	Preferred brand drugs	Not applicable	40% <u>coinsurance</u> with minimum & maximum/prescription: \$10 minimum & \$100 maximum (retail), \$20 minimum & \$200 maximum (mail order)	Not applicable	Not covered	
	Non-preferred brand drugs	Not applicable	40% <u>coinsurance</u> with minimum & maximum/prescription: \$10 minimum & \$100 maximum (retail), \$20 minimum & \$200 maximum (mail order)	Not applicable	Not covered	
	<u>Specialty drugs</u>	Not applicable	Applicable cost as noted above for generic or brand drugs	Not applicable	Not covered	Precertification required for coverage.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not applicable	20% <u>coinsurance</u>	Not applicable	40% <u>coinsurance</u>	None
	Physician/surgeon fees	20% <u>coinsurance</u>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	Not applicable	20% <u>coinsurance</u> after \$150 <u>copay</u> /visit, <u>deductible</u> doesn't apply	Not applicable	20% <u>coinsurance</u> after \$150 <u>copay</u> /visit, <u>deductible</u> doesn't apply	40% <u>coinsurance</u> after \$150 <u>copay</u> /visit, <u>deductible</u> doesn't apply for non-emergency use.

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Aexcel Designated Provider (You will pay the least)	Network Provider (You will pay more)	Aexcel Non-Designated Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
	<u>Emergency medical transportation</u>	Not applicable	20% <u>coinsurance</u>	Not applicable	20% <u>coinsurance</u>	Non-emergency transport: not covered, except if pre-authorized.
	<u>Urgent care</u>	Not applicable	20% <u>coinsurance</u>	Not applicable	40% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	Not applicable	20% <u>coinsurance</u> after \$200 <u>copay</u> /stay, <u>deductible</u> doesn't apply	Not applicable	40% <u>coinsurance</u> after \$200 <u>copay</u> /stay, <u>deductible</u> doesn't apply	<u>Pre-authorization</u> required for out-of-network care.
	Physician/surgeon fees	20% <u>coinsurance</u>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not applicable	Office & other outpatient services: 20% <u>coinsurance</u>	Not applicable	Office & other outpatient services: 40% <u>coinsurance</u>	None
	Inpatient services	Not applicable	20% <u>coinsurance</u> after \$200 <u>copay</u> /stay, <u>deductible</u> doesn't apply	Not applicable	40% <u>coinsurance</u> after \$200 <u>copay</u> /stay, <u>deductible</u> doesn't apply	<u>Pre-authorization</u> required for out-of-network care.
If you are pregnant	Office visits	Not applicable	No charge	Not applicable	40% <u>coinsurance</u>	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) <u>Pre-authorization</u> required for out-of-network care may apply.
	Childbirth/delivery professional services	20% <u>coinsurance</u>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Childbirth/delivery facility services	Not applicable	20% <u>coinsurance</u> after \$200 <u>copay</u> /stay, <u>deductible</u> doesn't apply; <u>copay</u> waived for newborn hospital expenses	Not applicable	40% <u>coinsurance</u> after \$200 <u>copay</u> /stay, <u>deductible</u> doesn't apply; <u>copay</u> waived for newborn hospital expenses	
If you need help recovering or have other special health needs	<u>Home health care</u>	Not applicable	20% <u>coinsurance</u>	Not applicable	40% <u>coinsurance</u>	130 visits/calendar year. <u>Pre-authorization</u> required for out-of-network care.
	<u>Rehabilitation services</u>	Not applicable	20% <u>coinsurance</u>	Not applicable	40% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Aexcel Designated Provider (You will pay the least)	Network Provider (You will pay more)	Aexcel Non-Designated Provider (You will pay more)	Out-of-Network Provider (You will pay the most)	
	<u>Habilitation services</u>	Not covered	20% <u>coinsurance</u>	Not covered	40% <u>coinsurance</u>	Limited to treatment of developmental delays.
	<u>Skilled nursing care</u>	Not applicable	20% <u>coinsurance</u> after \$200 <u>copay/stay</u> , <u>deductible</u> doesn't apply	Not applicable	40% <u>coinsurance</u> after \$200 <u>copay/stay</u> , <u>deductible</u> doesn't apply	90 days/calendar year. <u>Pre-authorization</u> required for out-of-network care.
	<u>Durable medical equipment</u>	Not applicable	20% <u>coinsurance</u>	Not applicable	40% <u>coinsurance</u>	Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse.
	<u>Hospice services</u>	Not applicable	20% <u>coinsurance</u>	Not applicable	40% <u>coinsurance</u>	<u>Pre-authorization</u> required for out-of-network care.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered	Not covered	Not covered.
	Children's glasses	Not covered	Not covered	Not covered	Not covered	Not covered.
	Children's dental check-up	Not covered	Not covered	Not covered	Not covered	Not covered.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- | | | |
|--|--|--|
| <ul style="list-style-type: none"> • Cosmetic surgery • Dental care (Adult & Child) • Glasses (Child) | <ul style="list-style-type: none"> • Long-term care • Routine eye care (Adult & Child) | <ul style="list-style-type: none"> • Routine foot care • Weight loss programs - Except for required preventive services. |
|--|--|--|

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- | | | |
|---|---|--|
| <ul style="list-style-type: none"> • Acupuncture - 12 visits/calendar year. • Bariatric surgery - Limited to Institutes of Quality contracted facility for in-network only. • Chiropractic care - 10 visits/calendar year. | <ul style="list-style-type: none"> • Hearing aids - 1 hearing aid to \$1,000 maximum per ear/36 months. • Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition. | <ul style="list-style-type: none"> • Non-emergency care when traveling outside the U.S. • Private-duty nursing |
|---|---|--|

Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is:

- For more information on your rights to continue coverage, contact the plan at 1-877-292-2480.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or : <https://www.dol.gov/agencies/ebsa>
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- If your coverage is a church plan, church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law.

Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

- Aetna directly by calling the toll free number on your Medical ID Card, or by calling our general toll free number at 1-877-292-2480.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <https://www.dol.gov/agencies/ebsa>
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- Additionally, a consumer assistance program can help you file your appeal. Contact information is at: <http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.html>.

Does this plan provide Minimum Essential Coverage? Yes.

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? Yes.

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

-----To see examples of how this plan might cover costs for a sample medical situation, see the next section.-----

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

■ The <u>plan's</u> overall <u>deductible</u>	\$400
■ <u>Specialist</u> <u>coinsurance</u>	20%
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	20%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	\$12,800
In this example, Peg would pay:	
<i>Cost Sharing</i>	
Deductibles	\$400
Copayments	\$0
Coinsurance	\$1,000
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$1,460

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$400
■ <u>Specialist</u> <u>coinsurance</u>	20%
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	20%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	\$7,400
In this example, Joe would pay:	
<i>Cost Sharing</i>	
Deductibles	\$400
Copayments	\$700
Coinsurance	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,320

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$400
■ <u>Specialist</u> <u>coinsurance</u>	20%
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	20%

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	\$1,900
In this example, Mia would pay:	
<i>Cost Sharing</i>	
Deductibles	\$400
Copayments	\$0
Coinsurance	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$700

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-877-292-2480.

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-877-292-2480.

Smartphone or Tablet

To view documents from your smartphone or tablet, the free WinZip app is required. It may be available from your App Store.

Non-Discrimination

Aetna complies with applicable Federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

Aetna provides free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator,

P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030 Fresno, CA 93779),

1-800-648-7817, TTY: 711, Fax: 859-425-3379 (CA HMO customers: 1-860-262-7705),

Email: CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates (Aetna).

Language Assistance:

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Hawaiian -	No ke kōkua ma ka ‘ōlelo Hawai‘i, e kahea aku i ka helu kelepona 1-877-292-2480. Kāki ‘ole ‘ia kēia kōkua nei.
Hindi -	हन्दिी में भाषा सहायता के लए, 1-877-292-2480 पर मुफ्त कॉल करें।
Hmong -	Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-877-292-2480.
Ibo -	Maka enyemaka asụsụ na Igbo kpọọ 1-877-292-2480 na akwughị ugwo ọ bụla
Ilocano -	Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-877-292-2480 nga awan ti bayadanyo.
Italian -	Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-877-292-2480.
Japanese -	日本語で援助をご希望の方は、1-877-292-2480 まで無料でお電話ください。
Karen -	လၢတၢ်မၤစၢၤတၢ်ကတိၤကိၣ်အီၣ် ကိၣ် ဂီၤ: 1-877-292-2480 လၢတၢ်အိၣ်ဒီးတၢ်လၢတၢ်သ့ၣ်လၢတၢ်စ့ၣ်
Korean -	한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-877-292-2480 번으로 전화해 주십시오.
Kru-Bassa -	Be'm'ké gbo-kpá-kpá dyé pidyi dé Bāsɔ́ɔ́-wuḍuiŋ wěɛ, d́á 1-877-292-2480
Kurdish -	برای راهنمایی به زبان فارسی با شماره 1-877-292-2480 به خۆرایێ یه‌یو‌مندی بکەن.
Laotian -	ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ1-877-292-2480 ໂດຍບໍ່ເສຍຄ່າໂທ.
Marathi -	तीलभाषा (मराठी) सहाय्यासाठी 1-877-292-2480 क्रमांकावरकोणत्याहीखर्चाशिवायकॉलकरा.
Marshallese -	Ñan bōk jipañ ilo Kajin Majol, kallok 1-877-292-2480 ilo ejjelok wōnān.
Micronesian-Pohnpeyan -	Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-877-292-2480 ni sohte isais.
Mon-Khmer, Cambodian -	សម្រាប់ជំនួយភាសាជា ភាសាខ្មែរ សូមទូរស័ព្ទទៅកាន់លេខ 1-877-292-2480 ដោយឥតគិតថ្លៃ។
Navajo -	T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-877-292-2480
Nepali -	(नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि 1- 877-292-2480 मा फोन गर्नुहोस् ।
Nilotic-Dinka -	Tën kuɔɔny ë thok ë Thuɔɔnjän col 1-877-292-2480 kec'in ayöc.
Norwegian -	For språkassistanse på norsk, ring 1-877-292-2480 kostnadsfritt.
Panjabi -	ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-877-292-2480 'ਤੇ ਮੁਫਤ ਕਾਲ ਕਰੋ।
Pennsylvania Dutch -	Fer Hefle in Deitsch, ruf: 1-877-292-2480 aa. Es Aaruf koschtet nix.
Persian -	برای راهنمایی به زبان فارسی با شماره 1-877-292-2480 بدون هیچ هزینه ای تماس بگیرید. انگلیسی
Polish -	Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-877-292-2480.

Portuguese -	Para obter assistência linguística em português ligue para o 1-877-292-2480 gratuitamente.
Romanian -	Pentru asistență lingvistică în românește telefonați la numărul gratuit 1-877-292-2480
Russian -	Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-877-292-2480.
Samoaan -	Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-877-292-2480 e aunoa ma se totogi.
Serbo-Croatian -	Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-877-292-2480.
Spanish -	Para obtener asistencia lingüística en español, llame sin cargo al 1-877-292-2480.
Sudanic-Fulfude -	Fii yo on hebu balal e ko yowitii e haala Pular noddee e oo numero doo 1-877-292-2480. Njodi woo fawaaki on.
Swahili -	Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-877-292-2480 bila malipo.
Syriac -	ܠܚܥܠܐ ܕܥܝܢܐ ܕܡܕܢܬܐ ܕܡܕܢܬܐ ܕܡܕܢܬܐ ܕܡܕܢܬܐ ܕܡܕܢܬܐ 1-877-292-2480 ܕܡܕܢܬܐ.
Tagalog -	Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-877-292-2480 nang walang bayad.
Telugu -	భాషతో సాయం కొరకు ఎలాంటి ఖర్చు లేకుండా 1-877-292-2480 కు కాల్ చేయండి. (తెలుగు)
Thai -	สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-877-292-2480 ฟรีไม่มีค่าใช้จ่าย
Tongan -	Kapau ‘oku fiema’u hā tokoni ‘i he lea faka-Tonga telefoni 1-877-292-2480 ‘o ‘ikai hā ʻōtōngi.
Trukese -	Ren ánninnisin chiakú ren (Kapasen Chuuk) kopwe kékkéeri 1-877-292-2480 nge esapw kamé ngonuk.
Turkish -	(Dil) çağrısı dil yardım için. Hiçbir ücret ödemedен 1-877-292-2480.
Ukrainian -	Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-877-292-2480.
Urdu -	اگر آپ کو کسی زبان کی مدد کی ضرورت ہے تو 1-877-292-2480 پر بلا فیس کال کریں۔
Vietnamese -	Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 1-877-292-2480.
Yiddish -	פאר שפראך הילף אין אידיש רופט 1-877-292-2480 פאר א פאצאל.
Yoruba -	Fún ìrànlọwọ nípa èdè (Yorùbá) pe 1-877-292-2480 láí san owó kankan rárá.